urgent cases or where the stricture is "resilient"—that is, a stricture that "will stretch like an elastic band and then contract again." Internal urethrotomy behind the triangular ligament is condemned under all circumstances, and external urethrotomy is as strongly urged for all strictures in this situation not curable by dilatation. Urethrotomy is condemned, as above, mainly for the reasons that as much can be secured by dilatation; that in either case dilatation must be indefinitely continued afterwards, and because the operation is far from being without inherent dangers. Divulsion is described as barbarous, unskilful, and a thing of the past. Cocaine as a urethral anæsthetic is condemned as an unsafe agent.

Certain of the complications of urethral gonorrhœa, such as gonorrhœa of other mucous membranes, gonorrhœal rheumatism, and acute and chronic gonorrhœal affections of the seminal vesicles (a knowledge of which conditions appears destined to revolutionize our ideas of the pathology and treatment of disorders of this region), and of the Fallopian tubes and peritoneum, receive neither mention nor consideration. On the other hand chancroid is described, but very well described, under the general heading of "Gonorrhœa and its Complications."

The chapters devoted to Syphilis are acceptably written by Dr. Hayden, presenting an abstract of the most generally taught doctrines of the subject, and following the general lines of one or two monographs of great popularity. The manifestations of syphilis as affecting each particular organ or region are elaborately, yet tersely, set forth, thus—as is characteristic of every portion of the work—making the essay valuable for clinical reference The now generally accepted belief is laid down that the diagnosis between infecting and non-infecting chancres cannot and should not be made, and that treatment for syphilis should never, excepting under certain self-evident but rare circumstances, be commenced prior to the appearance of secondary symptoms. Excision or other radical treatment of the primary sore is also condemned as useless in preventing constitutional infection; the lesion being regarded as a systemic, not a local symptom. Conventional treatment is advocated; it should be intermittent and extend over a period of from two to four years.

In press-work and freedom from typographical blemishes the volume leaves little to be desired. The illustrations, borrowed almost without exception from standard works, in the main very well elucidate the text. A good plate of the gonococcus would add to the completeness of the manual.

T. S. K. M.

THE JOHNS HOPKINS HOSPITAL REPORTS. I. REPORT IN PATHOLOGY. AMŒBIC DYSENTERY. By WILLIAM T. COUNCILMAN, M.D., and HENRI A. LAFLEUR, M.D. Baltimore: The Johns Hopkins Press, December, 1891.

THIS is an admirable study of a subject of general medical interest, and is conducted in a thoroughly scientific manner. Most of the work termed pathological is undeserving of the title, because it is confined to but one aspect of a many-sided subject. The true pathologist is he who endeavors to trace the relations between lesions and symptoms, and who must, therefore, be a clinician as well as a histologist. This first report on pathology from the Johns Hopkins Hospital is based upon clinical studies, and, it is to be hoped, will be an accepted model for further researches in the same field.

Before the publication of this report the existence of a form of dysentery due to an amœboid organism was recognized by a few, but, in future, it will be acknowledged by all. One of the strongest arguments in its support is the fact that it is frequently followed by an hepatic abscess presenting certain well-marked anatomical features, which distinguish it from all other forms of suppurative hepatitis. Our remarks will be confined to this relation between amœbic dysentery and hepatic abscess.

When the attention of the profession was first called to the relation between abscess of the liver and dysentery, it was supposed that the latter was secondary to the former, and induced by altered bile. In 1842, Dr. Budd, of England, perceived the true connection between the two diseases, and for a considerable period the view that hepatic abscess, when associated with dysentery, is secondary to the latter, met with general acceptance. Gradually, however, doubts concerning this fact began to rise, and it is no wonder that they became prevalent, for they were suggested by those whose experience of both diseases was greatest —*i. e.*, by physicians practising in India. It was argued that abscess of the liver does not occur in all epidemics of dysentery, and is comparatively uncommon in some countries where dysentery prevails. Now, admitting the truth of this observation, it might be due to the fact that the complex of symptoms called dysentery is not always the result of the same cause, and if this were demonstrated to be true, it might be further ascertained that some forms of dysentery are more liable than others to be followed by hepatic abscess. Both of these suppositions are undoubtedly correct. There is, as above stated, a form of dysentery caused by an amœboid organism in the large intestine which is peculiarly apt to be associated with abscess of the liver. The existence of this "amœbic dysentery" was long ago established by the researches of Lösch, Kartulis, and others, whose observations have been confirmed and extended by Councilman and Lafleur. Their report, based upon a study of fifteen cases, is the most valuable addition yet made to our knowledge of the subject. Among their conclusions is the following:

"Abscess of the liver, with or without involvement of the lung, is a frequent complication, much more so than in any other form of dysentery. The involvement of the lung may early follow hepatic involvement, and be detected by the occurrence of amœbæ in the sputum before there is evidence of liver abscess. These abscesses differ in their anatomical features from those produced by other causes. The chief difference is found in the absence of purulent inflammation, the abscess being caused by necrosis, softening, and liquefaction of the tissue. In these liver abscesses the amœbæ are not associated with other organisms."

It certainly sounds contradictory to describe as an abscess the result of a non-suppurative process, but in reality confusion is doubtless avoided by so doing, for the appearances described are universally spoken of as hepatic abscesses.

Although the primary focus of inflammation in these amœbic "abscesses" is in the portal district, it is probably by other channels than the venæ portæ that the amœbæ gain access to the liver. They do not enter the organ *via* the lymphatics, for they are not found in the lymph-glands belonging to the infected portion of intestine. The most significant fact with reference to this question of the route pursued by the amœbæ from the intestine to the liver is, that the abscesses in which they are found are on the under surface of the right lobe of that organ, in the immediate neighborhood of the hepatic flexure of the colon, and on the upper surface just beneath the diaphragm. When abscesses occur in the lung in these cases they are found in the lower lobe in contact with the diaphragm. Now, if the amœbæ were carried by the blood-current, the abscesses to which they give rise would not show such decided preferences as to site; and, on the other hand, these preferences are satisfactorily accounted for by a direct migration from the colon to the liver, in the cases of abscesses on the inferior surface of that organ; or by an indirect one *via* the peritoneal cavity, in the case of abscesses on the superior surface of the liver. This theory is confirmed by the constant site of abscess when it occurs in the lung, in the lowest portions of that organ—*i. e.*, at the point nearest the hepatic abscess.

One of the strongest arguments of those who deny the dysenteric origin of hepatic abscess is, that after death from the latter disease the most careful search has sometimes failed to reveal any sign of recent or old inflammation in the large intestine. Now, in such cases, it is possible that the amœbæ may have penetrated the intestinal wall and reached the liver without preceding ulceration of the colon. Councilman and Lafleur refer to this possibility, and they also suggest the passage of the amœbæ to the liver from the duodenum *via* the biliary passages. "The whole question of these abscesses of the liver," say they, "is one that should be cleared up; and with the abundant opportunities for their study which are offered in India and other tropical countries, we have no doubt that it will be."

The reviewer would take exception to this latter statement, for he is inclined to agree with the late Dr. Fagge that "the etiology of a disease can best be studied and its origin best unravelled in the countries where it is not too common." We believe that the "whole question of these abscesses of the liver" is rather more likely to be cleared up in Baltimore than in India.

In conclusion, we trust that it may not be considered hypercritical to call attention to a decided contradiction of the statement that amœbic abscesses are not purulent. On page 402 of the report, where reference is made to a case reported by Osler, who, by the way, was the first in America to recognize amœbic dysentery, it is stated that the amœbæ "were present in large numbers in the *creamy pus*[1] of the abscess."

F. P. H.

NERVE PROSTRATION AND OTHER FUNCTIONAL DISORDERS OF DAILY LIFE. By ROBSON ROOSE, M.D. Second edition. Pp. xxii., 691. London: H. K. Lewis, 1891.

IN this somewhat bulky volume a large number of common functional diseases of the nervous system, and some disorders of the heart, lungs,

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[1] Italics our own.